		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033779

Facility Name: Covenant Health Care Center-Northbrook

Address: 2155 Pfingsten Road (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 480-6380 **Fax #** (847) 480-7666

IDPA ID Number: 52-1115873001

Date of Initial License for Current Owners: 01/20/72

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Barry C. Scutillo, CPA **Telephone Number:** (954) 721-5222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/01 to 01/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Richard W. Olson
(Title) Vice President, Finance

Paid Preparer
(Signed) See Attached Accountants Report (Date)
(Print Name and Title) Scutillo Blake McMillan & Joyce, PA
(Firm Name & Address) 8000 North University Drive, Fort Lauderdale, Florida 33321
(Telephone) (954) 721-5222 Fax # (954) 722-6692

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,360	5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,736	27,998	1,832	34,566	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		21,336		21,336	12
13	DD 16 OR LESS					13
14	TOTALS	4,736	49,334	1,832	55,902	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.26%

D. How many bed-hold days during this year were paid by Public Aid? 8 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals On Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/20/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,832

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/31/02 Fiscal Year: 01/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	457,966	61,622	(740)	518,848		518,848		518,848			1
2	Food Purchase		395,706		395,706		395,706		395,706			2
3	Housekeeping	172,347	24,220	5,286	201,853		201,853		201,853			3
4	Laundry	25,742	15,597	108,278	149,617		149,617	(49,440)	100,177			4
5	Heat and Other Utilities			225,430	225,430		225,430		225,430			5
6	Maintenance	85,410	15,070	153,586	254,066		254,066	(2,835)	251,231			6
7	Other (specify):*											7
8	**TOTAL General Services**	741,465	512,215	491,840	1,745,520		1,745,520	(52,275)	1,693,245			8
	B. Health Care and Programs											
9	Medical Director			20,207	20,207		20,207		20,207			9
10	Nursing and Medical Records	2,504,722	71,749	19,838	2,596,309		2,596,309		2,596,309			10
10a	Therapy	85,544	569	38,977	125,090		125,090		125,090			10a
11	Activities	152,865	4,021	73,219	230,105		230,105	(22,891)	207,214			11
12	Social Services	100,488	83	543	101,114		101,114		101,114			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,843,619	76,422	152,784	3,072,825		3,072,825	(22,891)	3,049,934			16
	C. General Administration											
17	Administrative	127,905		363,336	491,241	(18,252)	472,989	140,947	613,936			17
18	Directors Fees											18
19	Professional Services			45,845	45,845		45,845		45,845			19
20	Dues, Fees, Subscriptions & Promotions			20,063	20,063		20,063	(3,846)	16,217			20
21	Clerical & General Office Expenses	290,198	14,689	54,728	359,615		359,615	(12,146)	347,469			21
22	Employee Benefits & Payroll Taxes			579,432	579,432	18,252	597,684		597,684			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,338	7,338		7,338	(3,666)	3,672			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,058	79,058		79,058	(604)	78,454			26
27	Other (specify):*											27
28	**TOTAL General Administration**	418,103	14,689	1,149,800	1,582,592		1,582,592	120,685	1,703,277			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,003,187	603,326	1,794,424	6,400,937		6,400,937	45,519	6,446,456			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Covenant Health Care Center-Northbrook #0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			573,766	573,766		573,766	(231,823)	341,943			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			341,223	341,223		341,223	(341,223)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,768	1,768		1,768		1,768			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			916,757	916,757		916,757	(573,046)	343,711			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		423,222	1,897	425,119		425,119		425,119			39
40	Barber and Beauty Shops	34,495		1,169	35,664		35,664		35,664			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							55,845	55,845			42
43	Other (specify):*	13,176		28,035	41,211		41,211	(40,872)	339			43
44	**TOTAL Special Cost Centers**	47,671	423,222	31,101	501,994		501,994	14,973	516,967			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,050,858	1,026,548	2,742,282	7,819,688		7,819,688	(512,554)	7,307,134			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(231,823)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(350,825)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,846)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(122,852)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (709,346)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	140,947		34
35	Other- Attach Schedule **Provider Part. Fee**	55,845	42	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 196,792		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (512,554)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Covenant Health Care Center-Northbrook

ID# 0033779

Report Period Beginning: 02/01/01

Ending: 01/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Conference, Seminar, Travel, Auto	$ (3,666)	24	1
2	Employee Recognition, Marketing	(40,872)	43	2
3	Cable Television Access	(22,891)	11	3
4	Offset Rental Revenue	(11,580)	21	4
5	Motor Vehicle Exp - Autos exceed limit	(943)	6	5
6	Auto Ins - Autos exceed limit	(201)	26	6
7	Amortize Loss on Early Ext. of Debt	9,602	32	7
8	Remove Maint Costs - Amortize over 3 yrs	(12,940)	6	8
9	Amortize Maint Costs Over 3 Yrs	12,933	6	9
10	Offset Laundry Revenue	(49,440)	4	10
11	Motor Vehicle Exp - Offset Trans Revenue	(1,885)	6	11
12	Auto Ins - Offset Trans Revenue	(403)	26	12
13	Offset Telephone Revenue	(566)	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(122,852)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(49,440)	0	0	0	0	0	0	0	0	0	0	(49,440)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,835)	0	0	0	0	0	0	0	0	0	0	(2,835)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(52,275)	0	0	0	0	0	0	0	0	0	0	(52,275)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(22,891)	0	0	0	0	0	0	0	0	0	0	(22,891)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(22,891)	0	0	0	0	0	0	0	0	0	0	(22,891)	16
	C. General Administration													
17	Administrative	0	140,947	0	0	0	0	0	0	0	0	0	140,947	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,846)	0	0	0	0	0	0	0	0	0	0	(3,846)	20
21	Clerical & General Office Expenses	(12,146)	0	0	0	0	0	0	0	0	0	0	(12,146)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,666)	0	0	0	0	0	0	0	0	0	0	(3,666)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(604)	0	0	0	0	0	0	0	0	0	0	(604)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,262)	140,947	0	0	0	0	0	0	0	0	0	120,685	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,428)	140,947	0	0	0	0	0	0	0	0	0	45,519	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Covenant Health Care Center-Northbrook **#** 0033779 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(231,823)	0	0	0	0	0	0	0	0	0	0	(231,823)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(341,223)	0	0	0	0	0	0	0	0	0	0	(341,223)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(573,046)	0	0	0	0	0	0	0	0	0	0	(573,046)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	55,845	0	0	0	0	0	0	0	0	0	0	55,845	42
43	Other (specify):*	(40,872)	0	0	0	0	0	0	0	0	0	0	(40,872)	43
44	**TOTAL Special Cost Centers**	14,973	0	0	0	0	0	0	0	0	0	0	14,973	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(653,501)	140,947	0	0	0	0	0	0	0	0	0	(512,554)	45

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Comm., Inc.	100.00%	See Attached List	Various	Cov. Retire. Comm.	Chicago	Mgt Svcs.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 363,336	Covenant Retirement Communities, Inc.	100.00%	$ 504,283	$ 140,947	1
2	V	19	Professional Services	45,845	Covenant Retirement Communities, Inc.	100.00%		(45,845)	2
3	V		Detail:						3
4	V	19	Audit Services				7,259	7,259	4
5	V	19	Data Processing				13,764	13,764	5
6	V	19	Cost Report Preparation				5,875	5,875	6
7	V	19	Payroll Processing				12,366	12,366	7
8	V	19	Legal Services				1,184	1,184	8
9	V	19	Benefits Consulting				4,129	4,129	9
10	V	19	Health Care Consulting				1,268	1,268	10
11	V								11
12	V	22	Pension Expense	5,424	Covenant Retirement Communities, Inc.		5,424		12
13	V								13
14	Total			$ 414,605			$ 555,552	$ * 140,947	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Retirement Communities, Inc.
Street Address: 5115 N. Francisco Ave., Suite 200
City / State / Zip Code: Chicago, Illinois 60625
Phone Number: (773) 878-2294
Fax Number: (773) 878-2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Fee	Actual Net Svc Rev	94,856,000	32	$ 5,391,331	$ 1,938,624	8,872,441	$ 504,283	1
2	19	Audit Services	Fixed Fee Per Mo. (1)	32	32	241,647	0	1	7,259	2
3	19	Data Processing	Fixed Fee Per Mo. (2)	32	32	474,064	Not Available	1	13,764	3
4	19	Cost Report Prep	Fixed Fee Per Mo. (3)	14	14	66,456	0	1	5,875	4
5	22	Pension Expense	Fixed Fee Per Mo. (4)	32	32	125,977	0	1	5,424	5
6	19	Payroll Processing	Direct Cost	1	1	12,366	0	1	12,366	6
7	19	Legal Fees	Direct Cost	1	1	1,184	0	1	1,184	7
8	19	Healthcare Consulting	Direct Cost	1	1	1,268	0	1	1,268	8
9	19	Benefits Consulting	Direct Cost	1	1	4,129	0	1	4,129	9
10										10
11										11
12										12
13										13
14		NOTE:								14
15		(1) Audit sevices are based upon a fixed fee of $605 per month. The general ledger is adjusted at year end to reflect actual expense.								15
16		(2) Data processing is based on a fixed fee of $1,147 per month.								16
17		(3) Medicare cost report preparation is based on a fixed fee of $490 per month.								17
18		(4) Pension plan expense is based on a fixed fee of $452 per month.								18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,318,422	$ 1,938,624		$ 555,552	25

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Senior Secured Note		X	Refinance of Debt		02/01/93	$ 780,600	$ 123,900	08/01/02	Variable	$ 17,763	1
2	1992 T/E Term Bonds		X	Refinance of Debt		02/01/93	1,898,492	1,221,203	12/01/15	Variable	92,811	2
3	1992 T/E 5 Yr. Extend. Bonds		X	Refinance of Debt		02/01/93	2,226,827	2,226,831	12/01/15	Variable	116,909	3
4												4
5	See Attached Schedule		X	Refinance of Debt		01/28/98	1,391,331	1,000,965	01/28/15	Variable	52,840	5
	Working Capital											
6	Interco Notes To/From CRC			Working Capital		02/01/95	(6,217,334)	(4,178,151)	N/A	Variable		6
7	Interco Debt Payable			Working Capital		02/01/95	(2,925,000)	(2,904,000)	N/A	Variable		7
8	Amort of C.O. Financing										60,900	8
9	TOTAL Facility Related						$ (2,845,084)	$ (2,509,252)			$ 341,223	9
	B. Non-Facility Related*											
10												10
11	Interest-See Attached Sch										(350,825)	11
12												12
13	Add: Amort loss in EE of debt										9,602	13
14	TOTAL Non-Facility Related						$	$			$ (341,223)	14
15	TOTALS (line 9+line14)						$ (2,845,084)	$ (2,509,252)			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Health Care Center-Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033779

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick-Masonary Frame Steel Studded Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Covenant Village of Northbrook Residential Independent Living Facility, 302,869 sq. ft., 306 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1973	$ 70,272	1
2					2
3	TOTALS			$ 70,272	3

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	166		1974	1974	$ 1,467,406	$ 36,685	40	$ 36,685	$	$ 1,045,527	4
5			1975	1975	2,250	56	40	56		1,546	5
6			1976	1976	1,916	48	40	48		1,302	6
7			1977	1977	2,769	69	40	69		1,765	7
8			1978	1978	7,643	191	40	191		4,681	8
	Improvement Type**										
9	Building Improvements - Brandel Care Center			1979	18,220	455	40	455		10,703	9
10				1980	20,844	521	40	521		11,725	10
11				1981	38,116	953	40	953		20,488	11
12				1982	3,360	84	40	84		1,722	12
13				1984	13,999	350	40	350		6,475	13
14				1985	162,076	4,052	40	4,052		70,786	14
15				1986	36,791	978	40	978		15,085	15
16				1987	17,303	433	40	433		6,705	16
17				1988	30,032	751	40	751		10,887	17
18				1989	472,871	11,822	40	11,822		159,594	18
19				1989	115,230	2,881	40	2,881		36,010	19
20				1990	77,922	1,948	40	1,948		22,402	20
21				1991	25,051	626	40	626		6,575	21
22				1992	7,901	198	40	198		1,878	22
23				1994	19,938	498	40	498		4,236	23
24	52 pairs of shear and rods - all patient rooms			1997	8,000	200	40	200		1,200	24
25	14 Cubicle curtains - wings 100 and 200			1997	2,636	66	40	66		396	25
26	A/C equipment			1998	3,549	89	40	89		400	26
27	Room remodeling			1999	2,989	75	40	75		262	27
28	Window treatments			1999	29,864	747	40	747		2,614	28
29	Heating A/C work			1999	1,665	42	40	42		147	29
30	New light fixtures			1999	1,647	41	40	41		145	30
31	Hall door replacement			1999	329	8	40	8		28	31
32	Roof repair/replacement			1999	133,950	3,349	40	3,349		11,721	32
33	New bathrooms			1999	9,685	242	40	242		847	33
34	Renovation/modernization - consulting fees, design			2000	39,980	1,000	40	1,000		2,505	34
35	architectural fees			2000	41,630	1,041	40	1,041		2,606	35
36	development cost - other			2000	41,531	1,038	40	1,038		2,588	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Renovation/modernization - primary architect fees	2000	$ 278,453	$ 6,961	40	$ 6,961	$	$ 17,405	37
38	inspection-testing fees	2000	3,143	79	40	79		199	38
39	architect/engineering-other	2000	3,615	90	40	90		225	39
40	building permits	2000	33,347	834	40	834		2,083	40
41	misc. city/county/state fees	2000	9,775	244	40	244		605	41
42	Village of Northbrook fees	2000	80	2	40	2		2	42
43	legal	2000	32,405	810	40	810		2,029	43
44	site work	2000	180,808	4,520	40	4,520		11,307	44
45	foundation/slab	2000	94,988	2,375	40	2,375		5,942	45
46	building costs	2000	2,875,182	71,880	40	71,880		179,682	46
47	job services	2000	364,637	9,116	40	9,116		22,797	47
48	other	2000	13,693	342	40	342		854	48
49	Alarm units	2000	2,204	55	40	55		82	49
50	Drapes	2000	69	2	40	2		3	50
51	Doors	2000	1,254	31	40	31		46	51
52	Finish resident rooms	2000	26,608	665	40	665		997	52
53	Remodel bath	2000	3,100	78	40	78		117	53
54	Roof Repair	2000	400	10	40	10		15	54
55	Painting	2000	780	20	40	20		30	55
56	Renovation/modernization - architect fees	2000	1,542	39	40	39		58	56
57	legal fees	2000	53	1	40	1		2	57
58	building costs	2000	142,383	3,560	40	3,560		5,340	58
59	job services	2000	25,939	648	40	648		972	59
60	Const. Costs - 400 & 200 Wing	2001	2,759	34	40	34		34	60
61	Const. Costs - 400 & 200 Wing	2001	5,858	73	40	73		73	61
62	Const. Costs - 400 & 200 Wing	2001	150	2	40	2		2	62
63	Remodel Fence	2001	1,750	22	40	22		22	63
64	Const. Costs - 400 & 200 Wing	2001	25,253	316	40	316		316	64
65	Const. Costs - 400 & 200 Wing	2001	7,262	91	40	91		91	65
66	Const. Costs - 400 & 200 Wing	2001	29,614	370	40	370		370	66
67	Const. Costs - 400 & 200 Wing	2001	44,200	553	40	553		553	67
68	Const. Costs - 400 & 200 Wing	2001	313	4	40	4		4	68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,070,710	$ 175,364		$ 175,364	$	$ 1,717,808	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,070,710	$ 175,364		$ 175,364	$	$ 1,717,808	1
2	Const. Costs - 400 & 200 Wings	2001	5,346	67	40	67		67	2
3	Const. Costs - 400 & 200 Wings	2001	625	8	40	8		8	3
4									4
5	Building Improvements - Axelson Manor								5
6		1987	9,537	238	40	238		3,695	6
7		1988	11,898	297	40	297		4,312	7
8		1989	25,256	631	40	631		8,523	8
9		1990	6,612	165	40	165		2,066	9
10		1991	5,581	140	40	140		1,606	10
11		1992	10,312	258	40	258		2,707	11
12		1993	10,084	252	40	252		2,395	12
13		1994	11,446	286	40	286		2,432	13
14		1995	4,965	124	40	124		934	14
15	Padding and carpeting	1996	3,410	85	40	85		554	15
16	Drapes and shears	1996	1,857	46	40	46		300	16
17	Carpet	1997	11,718	293	40	293		1,611	17
18	Food service renovations	1997	5,951	149	40	149		819	18
19	New building - Consulting fees, design & concept phase	1998	17,722	443	40	443		1,993	19
20	property concept/development cost	1998	13,384	335	40	335		1,507	20
21	primary architect fees	1998	179,191	4,480	40	4,480		20,165	21
22	collaborative architect rep fee	1998	215	5	40	5		23	22
23	inspection/testing fees	1998	1,701	43	40	43		187	23
24	architect and engineering, other	1998	2,675	67	40	67		301	24
25	building permits	1998	15,955	399	40	399		1,787	25
26	miscellaneous city/county/state fees	1998	2,221	56	40	56		254	26
27	fees and permits, other	1998	40	1	40	1		1	27
28	legal	1998	4,147	104	40	104		465	28
29	site work	1998	171,849	4,296	40	4,296		19,331	29
30	foundation/slab	1998	112,341	2,809	40	2,809		12,634	30
31	construction costs	1998	1,309,646	32,741	40	32,741		147,360	31
32	job services	1998	173,015	4,325	40	4,325		19,468	32
33	construction fee	1998	38,797	970	40	970		4,359	33
34	TOTAL (lines 1 thru 33)		$ 9,238,207	$ 229,477		$ 229,477	$	$ 1,979,672	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,238,207	$ 229,477		$ 229,477	$	$ 1,979,672	1
2	New Building - construction expenditures, other	1998	10,890	272	40	272		1,227	2
3	other	1998	6,480	162	40	162		721	3
4	New Carpet	1999	6,817	170	40	170		595	4
5	Drapes/shears for room	1999	554	14	40	14		49	5
6	New roof	1999	38,000	950	40	950		3,326	6
7	Additional Construction - architects fees	1999	2,416	60	40	60		211	7
8	Construction costs	1999	69,907	1,748	40	1,748		6,120	8
9	Floor covering	2000	3,308	83	40	83		124	9
10	Remodel Patio/Entrance	2001	20,000	250	40	250		250	10
11	Carpet Replacement - Common Areas	2001	2,665	33	40	33		33	11
12	Drapery Replacement - Common Areas	2001	269	3	40	3		3	12
13	Paving Entrance/Parking Lot	2001	36,342	454	40	454		454	13
14	Remodel Patio/Entrance	2001	8,547	107	40	107		107	14
15	Remodel Patio/Entrance	2001	940	12	40	12		12	15
16	Remodel Patio/Entrance	2001	20,697	259	40	259		259	16
17	Remodel Patio/Entrance	2001	4,575	57	40	57		57	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,470,614	$ 234,111		$ 234,111	$	$ 1,993,220	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,470,614	$ 234,111		$ 234,111	$	$ 1,993,220	1
2	Land Improvements								2
3		1982	14,374	719	20	719		14,737	3
4		1985	27,727	1,386	20	1,386		24,643	4
5		1989	1,500	75	20	75		1,012	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,514,215	$ 236,291		$ 236,291	$	$ 2,033,612	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 964,265	$ 329,749	$ 99,797	$ (229,952)	10	$ 381,485	71
72	Current Year Purchases	60,961	3,048	3,048		10	3,048	72
73	Fully Depreciated Assets	464,955				10	464,955	73
74								74
75	TOTALS	$ 1,490,181	$ 332,797	$ 102,845	$ (229,952)		$ 849,488	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Res. Trans., Maint.	Bus - 1987	1987	$ 32,205	$	$	$	4	$ 32,205	76
77	Resident Transportation	2 Busses - 1993	1993	68,425				5	68,425	77
78	Maintenance	Truck	1993	22,456				5	22,456	78
79	Resident Transportation	Bus - 2000	2000	14,034	4,678	2,807	(1,871)	5	4,210	79
80	TOTALS			$ 137,120	$ 4,678	$ 2,807	$ (1,871)		$ 127,296	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,211,788	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 573,766	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 341,943	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (231,823)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,010,396	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non Care Vehicles	$ 24,339	$	$ 24,339	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 24,339	$	$ 24,339	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [X] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	343	$	14,817	$	343	$ 14,817	1
2	Licensed Speech and Language Development Therapist	10a	hrs		90		3,891		90	3,891	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a	hrs		92		4,003		92	4,003	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39	# of prescrpts		21,164			416,101	21,164	416,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): X-Ray/Lab	39			188		1,897		188	1,897	13
14	TOTAL			$	21,877	$	24,608	$ 416,101	21,877	$ 440,709	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 01/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 170,329	$ 7,695,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 535,000)	556,397	8,478,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		9,136,000	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,171	1,388,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 727,897	$ 26,697,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,227,309	94,468,000	12
13	Land	500,768	15,815,000	13
14	Buildings, at Historical Cost	11,206,862	317,757,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,364,313	44,147,000	16
17	Accumulated Depreciation (book methods)	(4,552,542)	(123,145,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		39,547,000	21
22	Other Long-Term Assets (specify):	2,940,497	20,064,000	22
23	Other(specify): Construction In Progress		27,451,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,687,207	$ 436,104,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,415,104	$ 462,801,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 171,322	$ 6,267,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		2,819,000	28
29	Short-Term Notes Payable		7,685,000	29
30	Accrued Salaries Payable	231,185	3,014,000	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,381		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	49,270	1,540,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	7,596	3,426,000	36
37	Current Maturities-long term debt	228,774	5,370,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 697,528	$ 30,121,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,344,125	194,901,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interco Accts, Other Liabilities	(7,091,329)	12,340,000	43
44	Deferred Revenue		159,421,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,747,204)	$ 366,662,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,049,676)	$ 396,783,000	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 15,464,780	$ 66,018,000	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,415,104	$ 462,801,000	48

***(See instructions.)**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 14,153,313	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,153,313	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,318,628	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Planned Giving Assessment**	(7,161)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,311,467	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 15,464,780	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,075,475	1
2	Discounts and Allowances for all Levels	(708,048)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,367,427	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	355,311	6
7	Oxygen	11,740	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 367,051	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	58,192	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	465,041	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,825	19
20	Radiology and X-Ray		20
21	Other Medical Services	155,776	21
22	Laundry	49,440	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 738,274	23
	D. Non-Operating Revenue		
24	Contributions	144,416	24
25	Interest and Other Investment Income***	485,494	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 629,910	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Non Operating Revenue	35,653	28
28a	Rounding	1	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 35,654	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,138,316	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,745,520	31
32	Health Care	3,072,825	32
33	General Administration	1,582,592	33
	B. Capital Expense		
34	Ownership	916,757	34
	C. Ancillary Expense		
35	Special Cost Centers	501,994	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,819,688	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,318,628	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,318,628	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,390	1,656	$ 61,120	$ 36.91	1
2	Assistant Director of Nursing	2,444	2,788	72,380	25.96	2
3	Registered Nurses	33,050	36,297	915,858	25.23	3
4	Licensed Practical Nurses	1,823	2,071	41,481	20.03	4
5	Nurse Aides & Orderlies	88,485	98,818	1,365,219	13.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,248	2,524	85,544	33.89	7
8	Rehab/Therapy Aides					8
9	Activity Director	246	276	6,595	23.89	9
10	Activity Assistants	9,537	10,458	146,194	13.98	10
11	Social Service Workers	4,523	5,154	100,488	19.50	11
12	Dietician					12
13	Food Service Supervisor	5,080	5,935	130,677	22.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,127	31,682	327,289	10.33	15
16	Dishwashers					16
17	Maintenance Workers	4,198	4,546	85,410	18.79	17
18	Housekeepers	14,370	16,211	172,347	10.63	18
19	Laundry	1,853	2,034	25,742	12.66	19
20	Administrator	2,974	3,328	127,905	38.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,958	2,247	38,234	17.02	23
24	Clerical	16,207	17,412	265,140	15.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,369	1,642	30,873	18.80	31
32	Other Health Care(specify)					32
33	Other(specify)	3,110	3,318	52,362	15.78	33
34	TOTAL (lines 1 - 33)	223,992	248,397	$ 4,050,858 *	$ 16.31	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	101	$ 3,552	1, 3	35
36	Medical Director	1837/mo	20,207	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	170/mo	1,992	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	669	20,076	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	770	$ 45,827		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$		50
51	Licensed Practical Nurses	0			51
52	Nurse Aides	0			52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Duane Myers	Administrator	0	$ 64,974
Paul D. Peterson	Administrator	0	26,045
Neil Warnygora	Administrator	0	18,758
Ass't Admin - prior year correction			(124)
Employee Benefits			18,252
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,905

B. Administrative - Other

Description	Amount
	$
Management Services	363,336
TOTAL (agree to Schedule V, line 17, col. 3)	$ 363,336
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche, CPA	Audit Services	$ 7,259
ADP	Payroll Services	12,366
Covenant Retirement Comm	Data Processing	13,764
Covenant Retirement Comm	Legal Services	1,184
Seabury & Smith	Benefits Consultant	4,129
FR & R	Healthcare Consultant	1,268
Scutillo Blake McMillan & Joyce	Cost Report Preparation	5,875
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,845

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,869
Unemployment Compensation Insurance	3,554
FICA Taxes	274,324
Employee Health Insurance	266,591
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	5,174
Pension Plan Expense	5,424
Other	496
Reclass Administrator Emp Benefits	18,252
TOTAL (agree to Schedule V, line 22, col.8)	$ 597,684

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,874
Health Care Worker Background Check	
(Indicate # of checks performed)	
Promotion/Public Relations	834
Unallowable Promo/Pub. Relations	(834)
Dues and Subscriptions	17,355
Unallowable Dues & Subscriptions	(3,012)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,217

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 902
Non allowable Out of State Travel	(902)
In-State Travel	1,539
Non allowable In State Travel	(1,539)
Seminar Expense	4,897
Non allowable Seminar Expense	(1,225)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,672

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/01 Ending: 01/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Interior Repainting	12/98	$ 6,174	3	$ 172	$ 2,058	$ 2,058	$ 1,886	$	$	$	$	$
2	See Schedule	FY2000	14,525	3		1,917	4,842	4,842	2,924				
3	See Schedule	FY2001	17,054	3			2,211	5,686	5,686	3,471			
4	See Schedule	FY2002	12,940	3				2,405	4,315	4,315	1,905		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 50,693		$ 172	$ 3,975	$ 9,111	$ 14,819	$ 12,925	$ 7,786	$ 1,905	$	$

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/01 **Ending:** 01/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LNA $6,116**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,585** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **23,462**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte & Touche, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.